



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

August 15, 2007

Report Number: A-06-07-00058

Ms. Gerri Webb
Vice President
Government Programs
Chisholm Administrative Services
1215 S. Boulder
Tulsa, Oklahoma 74119-2800

Dear Ms. Webb:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Excessive Payments for Outpatient Services Processed by Chisholm Administrative Services in 2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me or Trish Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-07-00058 in all correspondence.

Sincerely,

A handwritten signature in black ink, which appears to read "Gordon L. Sato".

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

James R. Farris

Regional Administrator

Centers for Medicare & Medicaid Services, Region VI

1301 Young St., Suite 714

Dallas, TX 75202

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF EXCESSIVE
PAYMENTS FOR OUTPATIENT
SERVICES PROCESSED BY
CHISHOLM ADMINISTRATIVE
SERVICES IN 2005**



Daniel R. Levinson
Inspector General

August 2007
A-06-07-00058

Office of Inspector General

<http://oig.hhs.gov>

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Department of Health and Human Services

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THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

Chisholm Administrative Services (Chisholm) is a Medicare Part A intermediary serving Medicare providers in Oklahoma, including more than 150 hospitals. For claims with dates of service in calendar year 2005, Chisholm processed one outpatient claim that had payments of \$50,000 or more.

OBJECTIVE

Our objective was to determine whether the high-dollar Medicare payment that Chisholm made to a provider for an outpatient service was appropriate.

SUMMARY OF FINDING

The high-dollar Medicare outpatient payment was not appropriate. For calendar year 2005, Chisholm made one payment of \$50,000 or more for outpatient services. Our analysis indicated that, at the start of our fieldwork in February 2007, the payment was incorrect, and the provider had not refunded the \$57,700 overpayment. We notified the provider and requested that it review the claim. After reviewing the claim, the provider submitted an adjusted claim and refunded the overpayment. The Chisholm medical review team reviewed and approved the revised amount.

Contrary to Federal guidance, the provider inappropriately overstated the units of service on the high-dollar claim. Chisholm made this overpayment because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar year 2005 to detect billing errors related to units of service.

RECOMMENDATIONS

We recommend that Chisholm:

- review the provider's payment history for claims under \$50,000 that bill code C9205 and correct any claims found in error, and
- use the results of this audit in its provider education activities.

CHISHOLM'S COMMENTS

Chisholm Administrative Services agreed with our recommendations. Chisholm stated that it is currently analyzing claims made by the provider that totaled less than \$50,000 and contained code C9205. Chisholm added that it plans to take corrective action following the analysis.

Chisholm also stated that it has performed its fiscal year 2007 statewide provider education, "Medicare Billing Basics" which included a session on accurately using the Health Care Procedure Coding System and Current Procedure Terminology codes and accurately reporting the number of service units.

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INTRODUCTION

BACKGROUND

Fiscal Intermediary Responsibilities

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for Outpatient Services

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

In calendar year 2005, providers submitted approximately 141 million outpatient claims. Of these 141 million claims, only 401 claims resulted in payments of \$50,000 or more. We considered such claims to be at high risk for overpayment.

Chisholm

Chisholm Administrative Services (Chisholm) is a Medicare Part A intermediary serving Medicare providers in Oklahoma, including more than 150 hospitals. For claims with dates of service in calendar year 2005, Chisholm processed one outpatient claim that had a payment of \$50,000 or more.

The Social Security Act's definition of "provider of services" encompasses hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, renal dialysis facilities, and hospice programs. However, all providers with claims exceeding \$50,000 processed by Chisholm were hospitals; thus, the term "provider" as used in the remainder of this report refers to hospitals.

New Fiscal Intermediary Prepayment Edit

On January 3, 2006, after the end of our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends outpatient claims of \$50,000 or more and requires intermediaries to contact providers to determine the legitimacy of the claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the high-dollar Medicare payment that Chisholm made to a provider for an outpatient service was appropriate.

Scope

We reviewed the one outpatient claim for which Chisholm paid \$50,000 or more in calendar year 2005. We limited our review of Chisholm's internal control structure to those controls applicable to the one claim because our objective did not require an understanding of all internal controls over claims submission or claims processing. Our review allowed us to establish a reasonable assurance regarding the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our fieldwork at Chisholm's office in Tulsa, Oklahoma, during February 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify outpatient claims with Medicare payments of \$50,000 or more;
- reviewed available Common Working File claims histories for claims of \$50,000 or more to determine whether those claims had been canceled and superseded by a revised claim or whether the payments remained outstanding at the time of our fieldwork;
- contacted the provider with the outstanding payment to determine whether the units of service shown on the claim were correct and, if not, why the claim was billed in error and whether the provider agreed that a refund was appropriate; and
- coordinated our review with Chisholm.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

The high-dollar Medicare outpatient payment was not appropriate. For calendar year 2005, Chisholm made one payment of \$50,000 or more for outpatient services. Our analysis indicated that, at the start of our fieldwork in February 2007, the payment was incorrect, but the provider had not refunded the \$57,700 overpayment.

Contrary to Federal guidance, the provider inappropriately overstated the units of service on the high-dollar claim. Chisholm made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar year 2005 to detect billing errors related to units of service.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). Section 3627.8(C) of the “Medicare Intermediary Manual” states: “The definition of service units is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the ‘number of times the service or procedure being reported was performed.’” Furthermore, the “Hospital Manual,” section 462, states: “In order to be paid correctly and promptly, a bill must be completed accurately.”

Section 3700 of the “Medicare Intermediary Manual” states: “It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments.”

INAPPROPRIATE CLAIMS SUBMISSIONS

The claim for \$50,000 or more resulted in an inappropriate payment. The provider billed incorrect and excessive units of service for the drug Eloxitan. Our analysis showed that the outpatient claim for calendar year 2005 contained an overpayment totaling \$57,700. We gave the claim to both Chisholm and the provider for correction. After reviewing the claim, the provider submitted an adjusted claim and refunded the overpayment. The Chisholm medical review team reviewed and approved the revised amount.

CAUSES OF OVERPAYMENTS

The provider agreed that the overpayment occurred on the claim and submitted an adjusted claim. The provider attributed the incorrect claim to an error that occurred while converting the drug’s dosage amount to billing units; as a result, the billing units were overstated. The oncology nurse was using the J9263 code description of 0.5 mg per billing unit rather than the Medicare C9205 code description of 5 mg per billing unit for the drug Eloxitan.

In addition, during calendar year 2005, Chisholm did not have prepayment or postpayment controls to identify aberrant payments at the claim level, and the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments to providers. In effect, Medicare relied on providers to notify the intermediaries of excessive payments and on beneficiaries to review their “Explanation of Medicare Benefits” and disclose any overpayments made to providers.

RECOMMENDATIONS

We recommend that Chisholm:

- review the provider's payment history for claims under \$50,000 that bill code C9205 and correct any claims found in error and
- use the results of this audit in its provider education activities.

CHISHOLM'S COMMENTS

Chisholm Administrative Services agreed with our recommendations. Chisholm stated that it is currently analyzing claims made by the provider that totaled less than \$50,000 and contained code C9205. Chisholm added that it plans to take corrective action following the analysis.

Chisholm also stated that it has performed its fiscal year 2007 statewide provider education, "Medicare Billing Basics" which included a session on accurately using the Health Care Procedure Coding System and Current Procedure Terminology codes and accurately reporting the number of service units.

APPENDIX

07/26/07 16:23 FAX 918 560 3506

CHISHOLM ADM SVCS BCBSOK

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Chisholm Administrative Services

P.O. Box 3404
Tulsa, OK 74101-3404



Gordon L. Sato
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

July 16, 2007

RE: Response to Draft Report Number: A-06-07-00058

Dear Mr. Sato:

Thank you for the opportunity to review the referenced draft report "Review of Excessive Payments for Outpatient Services Processed by Chisholm Administrative Services in 2005."

We agree with the recommendations. Currently, we are performing data analysis to identify the provider's claims under \$50,000 that contained the code C9205. We plan to proceed with corrective action following data analysis.

We have performed our FY 2007 statewide provider education, "Medicare Billing Basics." This education includes a session on accurate billing / coding of Health Care Procedure Coding System (HCPCS) codes, Current Procedure Terminology (CPT) codes, and number of units. We discuss the potential impact of accurate billing on reimbursement. We also include a session on benefit integrity.

07/26/07 16:24 FAX 918 560 3506

CHISHOLM ADM SVCS BCBSOK

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If you have any additional questions or concerns, contact Donna Payne, Claims Manager, 918-551-2269, or Pam Beene, Claims Supervisor, 918-551-2531.

Sincerely,

A handwritten signature in cursive script that reads "Donna Payne".

Donna Payne, R.N., Manager
Medicare Part A Medical Review / Claims Operations
Chisholm Administrative Services

Cc: Mark Smith, Medicare CFO
Tracy McKenzie, Internal Audit